

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/18/2006	
NAME OF PROVIDER OR SUPPLIER ROSEWOOD REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2045 SILVERADA BLVD. RENO, NV 89512			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 13812 This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 12/18/06.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>Complaint #NV00013525 alleged that the facility failed to assist residents during meals, failed to provide enough staff to assist residents with meals, and failed to ensure that the food was not cold. The complaint was unsubstantiated.</p> <p>Complaint #NV00013540 alleged that the facility failed to keep refrigerators clean, failed to dispose of outdated drugs in the medication room, and failed to keep the dining room clean. The complaint was unsubstantiated.</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.